Client Data Project (CDP):
Client-Level Encounter Form
OMB # 0915-0275
Expires: 12/31/2007

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0915-0275.. Public reporting burden for this collection of information is estimated to average 1.5 hours per client per year, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to HRSA Reports Clearance Officer, 5600 Fishers Lane, Room 14-33, Rockville, Maryland, 20857.

Client Encounter Form

1. URN or Unique ID: _____

2. ZIP code of residence: __ __ __ __ __

3. Provider ID: _____

4. Date of enrollment: __ __/ __ __ / __ __ __ __

(mm/dd/yyyy)

5. Gender:

1-☐ Male
2-☐ Female
3-☐ Transgender
9-☐ Unknown/unreported

6. Year of birth: __ __ __ __

7. If year of birth is unknown, what is client's estimated age: _____

8. Is the client of Hispanic or Latino/a ethnicity?

0-☐ No
1-☐ Yes

9. What is the client's race? *(Check all that apply.)*

1-☐ White
1-☐ Black or African American
1-☐ Asian
1-☐ Native Hawaiian/Pacific Islander
1-☐ American Indian or Alaska Native

10. If the client is new to your service this year, did they enter HIV primary medical care as a result of a routine HIV counseling and testing program?

0-☐ No
1-☐ Yes, at this agency
2-☐ Yes, at another counseling and testing site
7-☐ Not applicable
9-☐ Unknown/unreported

11. What is the client's household income?

1-☐ Equal to or below the Federal poverty line
2-☐ 101–200% of Federal poverty line
3-☐ 201–300% of Federal poverty line
4-☐ > 300% of Federal poverty line
9-☐ Unknown/unreported

12. Current housing/living arrangement:

0-☐ Permanently housed
1-☐ Non-permanently housed
2-☐ Institution
8-☐ Other
9-☐ Unknown/unreported

13. Current HIV/AIDS status:

1-☐ HIV-positive, not AIDS
2-☐ HIV-positive, AIDS status unknown
3-☐ CDC-defined AIDS
4-☐ HIV Indeterminate (< 2 years of age)
4-☐ HIV-negative (affected clients only)
9-☐ Unknown/unreported (affected)

14. What is the client's vital/enrollment status?

1-☐ Active
2-☐ Deceased
3-☐ Inactive
9-☐ Unknown

15. Current source of medical insurance:

1-☐ Private
2-☐ Medicare
3-☐ Medicaid
4-☐ Other public
5-☐ No insurance
8-☐ Other
9-☐ Unknown/unreported

a. If "Other," describe: _____

16. Primary risk factor for HIV infection *(Check one only.)*

1-☐ Male who has sex with male(s) (MSM)
2-☐ Injection drug user (IDU)
3-☐ Male who has sex with male(s) and injection drug user (MSM and IDU)
4-☐ Hemophilia/coagulation disorder
5-☐ Heterosexual contact

6-☐ Receipt of transfusion of blood, blood components, or tissue
7-☐ Mother with/at risk for HIV infection (perinatal transmission)
8-☐ Other
9-☐ Undetermined/unknown/risk not reported

17. Does the client have a documented diagnosis of, or were they treated or referred for, substance abuse at any time this year (including injection drugs, alcohol)?

0-☐ No
1-☐ Yes

18. Does the client have a documented diagnosis of, or were they treated or referred for, a mental health condition at any time this year?

0-☐ No
1-☐ Yes

19. Service Visits

Indicate the number of service visit received. Except for services aa and ab, Do NOT include *outside* referrals here.

Type of Service	Total Number of Service Visits
a. Ambulatory/outpatient medical care	_____
b. Mental health services	_____
c. Oral health care	_____
d. Substance abuse services–Outpatient	_____
e. Substance abuse services–Residential	_____
f. Rehabilitation services	_____
g. Home health: para-professional care	_____
h. Home health: professional care	_____
i. Home health: specialized	_____
j. Case management services	_____
k. Buddy/companion service	_____
l. Child care services	_____
m. Child welfare services	_____
n. Client advocacy	_____
o. Day or respite care for adults	_____
p. Developmental assessment/early intervention services	_____
q. Early intervention services for Titles I and II	_____
r. Emergency financial assistance	_____
s. Food Bank/home-delivered meals	_____
t. Health education/risk reduction	_____
u. Housing services	_____
v. Legal services	_____
w. Nutritional counseling	_____
x. Outreach services	_____
y. Permanency planning	_____
z. Psychosocial support services	_____
aa. Referral for health care/supportive services	_____
ab. Referrals to clinical research	_____
ac. Residential or in-home hospice care	_____
ad. Transportation services	_____
ae. Treatment adherence counseling	_____
af. Other services	_____

Medical Information

20. a. Was client counseled about HIV transmission risk behaviors as part of their primary medical care?

0-☐ No
1-☐ Yes
7-☐ Not applicable
8-☐ Not medically indicated
9-☐ Unknown/unreported

b. If 20a is yes, who performed the counseling? (Check all that apply)

1-☐ Primary care clinician
2-☐ Case manager/social worker
3-☐ Other trained counselor

Clinical Follow-up: Prevention and Treatment

21. Tuberculosis screening and treatment

a. Date or Year of most recent TB skin test:

__ __/ __ __ __ __ (mm/yyyy)

b. Result of the most recent TB skin test.

0-☐ Negative (<5 mm)
1-☐ Positive (>=5 mm)
2-☐ Inconclusive
9-☐ Did not return for reading/lost to follow-up

c. Documented history of treatment for TB disease or prophylaxis for latent TB infection**?**

0-☐ No
1-☐ Prophylaxis for latent TB infection
2-☐ Treatment for active disease
9-☐ Unknown/lost to follow-up

d. If 21C =1 or 2, enter date treatment: **started:** mm/yyyy

e. If 21C =1 or 2, enter date treatment: **completed**: mm/yyyy (Year only is adequate)

22. a. Was client screened for syphilis?

0-☐ No
1-☐ Yes
8-☐ Not medically indicated

b. If syphilis treatment was indicated, was it prescribed?

0-☐ No
1-☐ Yes
9-☐ Unknown/unreported

23. a. Was client screened for any sexually transmitted infection (STI) other than syphilis and HIV?

0-☐ No
1-☐ Yes
8-☐ Not medically indicated

b. If treatment was indicated for any STI other than syphilis and HIV was it prescribed?

0-☐ No
1-☐ Yes

24. Hepatitis A

a. Is client Hepatitis A antibody positive?

0-☐ No
1-☐ Yes

b. If antibody positive, enter date of last positive Total Hep A Antibody test**: __ __/__ __ __ (mm/yyyy)**

c. Date of first Hepatitis A vaccine dose: __ __/__ __(mm/yyyy)

d. **Date of second Hepatitis A vaccine dose**: __ __/__ __ (mm/yyyy)

25. Hepatitis B

a. Is client positive for Hepatitis B positive(any Ab or antigen)?

0-☐ No
1-☐ Yes

b. If Hep B positive, enter d**ate of last positive** : __ __/__ __ __ __ (mm/yyyy)

Enter vaccination dates if applicable

a. Date of first Hep. B vaccine dose: __ __/__ __ __ __

b. Date of second Hep. B vaccine dose: __ __/__ __ __ __

c. Date of third Hep. B vaccine dose: __ __/__ __ __ __

26. Hepatitis C

a. Date of most recent hepatitis C screening test:

__ __/__ __ __ __ (mm/yyyy)

b. Was client evaluated for hepatitis C treatment?

0-☐ No
1-☐ Yes

c. Was client treated for hepatitis C?

0-☐ No
1-☐ Yes

d. If treated, date therapy started: __ __/__ __ __ __

e. If treated, **date therapy completed**: __ __/__ __ __ __

Other Recommended Vaccines

27. Date of last Pneumovax: __ __/__ __/__ __ __ __

28. Date of last influenza vaccine: __ __/__ __/__ __ __ __

29. Enter CD4+ lymphocyte counts (cells/L),Viral Loads and PCP prophylaxis treatment information:

Test Date	CD4+ Count	If CD4+ Count<200, Indicate if PCP Proph. Prescribed	Viral Load (Enter 0 if undetectable)
_ _/_ _/_ _ _ _	_ _ _ _	___ 0=No 1=Yes	_ _ _, _ _ _
_ _/_ _/_ _ _ _	_ _ _ _	___	_ _ _, _ _ _
_ _/_ _/_ _ _ _	_ _ _ _	___	_ _ _, _ _ _
_ _/_ _/_ _ _ _	_ _ _ _	___	_ _ _, _ _ _

30. Check if client was newly diagnosed with any of the following AIDS-defining conditions (check all that apply):

- ☐ Cervical cancer
- ☐ Cytomegalovirus disease
- ☐ Lymphoma
- ☐ Mycobacterium avium complex
- ☐ Mycobacterium tuberculosis
- ☐ Pneumocystis carinii pneumonia
- ☐ Toxoplasmosis
- ☐ Other AIDS-defining condition

31. a. Was the client prescribed antiretrovirals at anytime during the year?

0=No; 1=Yes

31b. If applicable, check the latest antiretroviral drug regimen each quarter:

Code	Brand name (Generic)	q1	q2	q3	q4
1	Agenerase (amprenavir)				
2	Combivir (lamivudine/zidovudine)				
3	Crixivan (indinavir)				
4	Emtriva (emtricitabine)				
5	Epivir (3TC, lamivudine)				
6	Epzicom (lamivudine/abacavir)				
7	Fortovase (saquinavir)				
8	Fuzeon (enfuvirtide)				
9	HIVID (ddC, dideoxycytidine, zalcitabine)				
10	Invirase (saquinavir mesylate)				
11	Kaletra (ritonavir, lopinavir)				
12	Lexiva (fosamprenavir)				
13	Norvir (ritonavir)				
14	Rescriptor (delavirdine)				
15	Retrovir (AZT, ZDV, zidovudine)				
16	Reyataz (atazanavir sulfate)				
17	Sustiva (efavirenz)				
18	Trizivir (Abacavir/3TC/AZT)				
19	Truvada (emtricitabine, tenofovir)				
20	Videx (ddI, didanosine, dideoxyinosine)				
21	Viracept (nelfinavir)				
22	Viramune (nevirapine)				
23	Viread (Tenofovir)				
24	Zerit (d4T, stavudine)				
25	Ziagen (abacavir)				
99	Other ARV (experimental)				

31c. If client did not take any antiretrovirals for any continuous 3 month period or longer with the year, indicate reason:

1 - ☐ Not medically indicated
2 - ☐ Not ready (as determined by clinician)
3 - ☐ Client refused therapy
4 – ☐ Intolerance, side-effects, toxicity
5 - ☐ Managed treatment interruption
6 - ☐ Non-adherent
7 - ☐ Other (comorbidty including substance use, mental health problems, inability to pay/lack of adequate insurance)

Questions 33-35 for Females only

32.☐a. Date of last pelvic exam: __ __/__ __/__ __ __ __

b. If no exam, indicate reason:

0-☐ Not medically indicated
1-☐ Refused

33.☐

a. Date of last vaginal Pap smear: __ __/__ __/__ __ _ _

b. If no exam, indicate reason:

0-☐ Not medically indicated
1-☐ Refused

34. Pregnancy history/Maternal to child HIV transmission

a. Was the client pregnant this year?

0-☐ No 1-☐Yes

b. If pregnant, during what trimester did the client <u>begin</u> prenatal/perinatal care?

1-☐ First trimester
2-☐ Second trimester
3-☐ Third trimester
4-☐ At time of delivery
9-☐ Unknown/unreported

c. Did the client receive antiretroviral medications to prevent maternal to child transmission of HIV?

0-☐ No
1-☐ Yes

d. Did the client deliver any (liveborn) children this year?

0-☐ No
1-☐ Yes
9-☐ Unknown/unreported

e. Total number of livebirths:__ __

f. If 345d. is yes, did newborn(s) receive recommended HIV preventive therapies?

0-☐ No
1-☐ Yes
9-☐ Unknown/unreported

g. Of the children reported in *#34 e,* what was their HIV status at the end of the reporting period?

_____ No. HIV positive, confirmed

_____ No. HIV indeterminate

_____ No. HIV negative, confirmed

35. Was this client referred outside your EIS program (Title III) and/or your network (Title IV) for any service that was unavailable within your program or network this year?

0-☐ No *(Client-level form complete.)*
1-☐ Yes
9-☐ Unknown/unreported *(Client-level form complete.)*

36. Indicate the type of outside referral and if the client received the service:

		Service Received?		
Type of Service	**Referred?**	**No**	**Yes**	**Unknown**
Ambulatory/outpatient medical care	1-☐	0-☐	1-☐	9-☐
Mental health services	1-☐	0-☐	1-☐	9-☐
Oral health care	1-☐	0-☐	1-☐	9-☐
Substance abuse services–Outpatient	1-☐	0-☐	1-☐	9-☐
Substance abuse services–Residential	1-☐	0-☐	1-☐	9-☐
Rehabilitation services	1-☐	0-☐	1-☐	9-☐
Home health: para-professional care	1-☐	0-☐	1-☐	9-☐
Home health: professional care	1-☐	0-☐	1-☐	9-☐
Home health: specialized	1-☐	0-☐	1-☐	9-☐
Case management services	1-☐	0-☐	1-☐	9-☐
Buddy/companion service	1-☐	0-☐	1-☐	9-☐
Child care services	1-☐	0-☐	1-☐	9-☐
Child welfare services	1-☐	0-☐	1-☐	9-☐
Client advocacy	1-☐	0-☐	1-☐	9-☐
Day or respite care for adults	1-☐	0-☐	1-☐	9-☐
Developmental assessment/early intervention services	1-☐	0-☐	1-☐	9-☐
Early intervention services for Titles I and II	1-☐	0-☐	1-☐	9-☐
Emergency financial assistance	1-☐	0-☐	1-☐	9-☐
Food Bank/home-delivered meals	1-☐	0-☐	1-☐	9-☐
Health education/risk reduction	1-☐	0-☐	1-☐	9-☐
Housing services	1-☐	0-☐	1-☐	9-☐
Legal services	1-☐	0-☐	1-☐	9-☐
Nutritional counseling	1-☐	0-☐	1-☐	9-☐
Outreach services	1-☐	0-☐	1-☐	9-☐
Permanency planning	1-☐	0-☐	1-☐	9-☐
Psychosocial support services	1-☐	0-☐	1-☐	9-☐
Referral for health care/supportive services	1-☐	0-☐	1-☐	9-☐
Referrals to clinical research	1-☐	0-☐	1-☐	9-☐
Residential or in-home hospice care	1-☐	0-☐	1-☐	9-☐
Transportation services	1-☐	0-☐	1-☐	9-☐
Treatment adherence counseling	1-☐	0-☐	1-☐	9-☐
Other services	1-☐	0-☐	1-☐	9-☐

CLIENT-LEVEL FORM COMPLETE.